



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Emergency Services

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## ***Revision History***

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<b>Version</b>	<b>Date</b>	<b>Reason for Revisions</b>	<b>Completed By</b>
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: August 25, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 Published: September 8, 2016	Interim update	FSSA and HPE
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# Emergency Services

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the fee-for-service (FFS) delivery system. For information about services provided through the managed care delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

*For updates to the information in this module, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

## Introduction

Emergency services include unscheduled episodic services provided to individuals who require immediate medical attention. An **emergency service** is a service provided to a member after the sudden onset of an emergency medical condition.

As defined by *Indiana Administrative Code 405 IAC 5-2-9* and *United States Code 42 USC 1395dd(e)(1)*, an **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

## Emergency Service Coverage and Billing

The Indiana Health Coverage Programs (IHCP) provides reimbursement for emergency services provided to IHCP members. Guidelines for these services are subject to the member's program enrollment.

Providers should bill for emergency services using the appropriate type of claim for their provider type and specialty. For example, facilities should bill using the institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal [Portal] institutional claim, or 837I electronic transaction), and physicians should bill using the professional claim (*CMS-1500* claim form, Portal professional claim, or 837P electronic transaction).

For information about emergency services related to specific specialties, see the appropriate module, such as [Dental Services](#), [Hospice Services](#), [Inpatient Hospital Services](#), [Mental Health and Addiction Services](#), [Pharmacy Services](#), or [Transportation Services](#).

### ***Exclusions for Prior Authorization, Referrals, and Copayments***

Emergency services as defined in this document do not require prior authorization (PA). However, any inpatient stay resulting from an emergency admission *does* require PA, with the exception of stays for burn care with an admission of type 1 (emergency) or type 5 (trauma) or stays for services that are exempt from inpatient PA requirements, as described in the [Inpatient Hospital Services](#) module. To receive IHCP reimbursement for inpatient services, emergency admissions must be reported to the PA contractor within 48 hours after admission, not including Saturdays, Sundays, or legal holidays.

Emergency services are self-referral services. Members on restricted utilization through the Right Choices Program may receive treatment without a referral from the authorized provider if the diagnosis is an emergency diagnosis.

Emergency services are excluded from fee-for-service copayment requirements.

## ***Package E Members***

Coverage for *Package E – Emergency Services Only* members is limited to *only* emergency services. For these members, services must meet the emergency criteria noted in the [Introduction](#) section to be eligible for IHCP reimbursement. In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions. For more information about Package E eligibility and benefit criteria, see the [Member Eligibility and Benefit Coverage](#) module.

Covered services for Package E members are reimbursed under the fee-for-service delivery system. When billing for Package E members, providers must indicate in the appropriate field on the claim that the service rendered meets the definition of an emergency service. Providers are responsible for maintaining documentation to support the claim and the appropriateness of the service.

For coverage of emergency services rendered to Package E members, claims must indicate that the service is an emergency, as follows:

- **Professional** claims (*CMS-1500* claim form or electronic equivalent) must have the emergency indicator (EMG) field marked for each service detail.
- **Institutional outpatient** claims (*UB-04* claim form or electronic equivalent) must include an emergency diagnosis code in the principal (primary) position.
- **Institutional inpatient** claims (*UB-04* claim form or electronic equivalent) must include an admission type code of 1, indicating an emergency admission.
- **Dental** claims must have the word *Emergency* in the Predetermination/Preauthorization Number field for paper claims (*ADA 2012* claim form) or the emergency indicator field marked for electronic claims (Portal dental claim or 837D electronic transaction), and the procedure must be for an IHCP-designated emergency dental service (see the *Dental Procedure Codes Allowed for Package E Members* table in *Dental Services Codes*, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)).
- **Pharmacy** claims must have the emergency indicator field marked, must be for a limited-supply prescription (a maximum of 4 days) associated with a covered emergency medical service, and must be submitted on a paper pharmacy claim.

For more detailed Package E billing instructions, see the *Emergency Services Only (Package E) Billing* section of the [Claim Submission and Processing](#) module.

## **Services Provided in an Emergency Department**

The IHCP covers services for a member presenting to an emergency department with an emergency medical condition, as determined by the screening physician.

- The IHCP provides reimbursement to emergency department physicians who render medically necessary emergency services to IHCP members.
- Claims for related services (such as facility charge, lab, and x-ray) provided in an emergency room setting must include a principal diagnosis code that supports the emergency nature of the service; otherwise, the IHCP may suspend the claim for review to determine whether the prudent layperson standard has been met. If the IHCP review determines that the prudent layperson standard has not been met, the IHCP will deny the claim.



Facility charges for emergency department visits are billed and reimbursed as described in the [Outpatient Facility Services](#) module. If the emergency department visit results in an inpatient stay, reimbursement is included in the inpatient diagnosis-related group (DRG), as described in the [Inpatient Hospital Services](#) module.

## ***Emergency Department Screenings***

Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. Billing guidelines for the institutional claim (*UB-04* claim form or electronic equivalent) depend on the result of the screening, as follows:

- If the screening result does **not** meet the definition of an emergency visit, using the prudent layperson review criteria, the hospital should bill **only** for the screening service, using revenue code 451 – *Emergency Medical Treatment and Labor Act [EMTALA] Emergency Medical Screening Services*. No emergency room treatment services are reimbursed if billed in conjunction with revenue code 451.
- If the screening determines that the member **does** have an emergency condition, the hospital should **not** bill revenue code 451 for the screening. Instead, the hospital should bill for the medically necessary emergency services provided, using the appropriate revenue code (such as 450 – *Emergency Room – General*) along with applicable procedure codes.

Physicians bill for their services on a professional claim (*CMS-1500* claim form or electronic equivalent), and must use Current Procedural Terminology (CPT<sup>®1</sup>) codes 99281–99285 to reflect the appropriate level of emergency department screening exam performed.

## ***Nonemergency Services Provided in an Emergency Department***

The IHCP does not reimburse hospitals for nonemergency services rendered in emergency room settings. Hospitals are reimbursed for screenings that are necessary to determine whether the member has an emergency condition. If the screening does not indicate an emergency medical condition, the hospital is reimbursed only for the screening itself, billed with revenue code 451. All ancillary charges submitted with revenue code 451 will be denied, with the explanation of benefits (EOB) code 4180 – *When revenue code 451 is billed on an outpatient or outpatient crossover claim, all other services billed are not payable*.

Physicians who provide services in an emergency department setting to patients whose screenings do not indicate an emergency medical condition should bill these nonemergency services using the applicable office visit procedure code instead of the emergency room screening procedure code. The claim should be billed with the applicable place-of-service code for the emergency department setting. The IHCP will apply a site-of-service reduction in the reimbursement, if applicable, as described in the [Medical Practitioner Reimbursement](#) module.

*Note: Some managed care members are required to pay a copayment for nonemergency services provided in the emergency department. See the [Member Eligibility and Benefit Coverage](#) module for details.*

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